Supreme Court, U.S.
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No. 95-442 SEP 15 1995

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In The

Supreme Court of the United States

October Term, 1995

U.S. HEALTHCARE, INC.,

Petitioner,

v.

CECILIA DUKES, Trustee Ad Litem of the Estate of Darryl Dukes, Deceased,

Respondent.

U.S. HEALTHCARE, a/k/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA/NJ,

Petitioner,

v.

SERENA MARY VISCONTI, DECEASED, BY LINDA AND RONALD VISCONTI, AS ADMINISTRATORS OF THE ESTATE OF SERENA MARY VISCONTI, DECEASED; LINDA VISCONTI; RONALD VISCONTI, IN THEIR OWN RIGHT,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether this Court should issue a writ of certiorari to review the decision of the United States Court of Appeals for the Third Circuit that the "complete preemption" doctrine set forth in *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), does not apply to a state court action brought by a beneficiary of an employee benefit plan governed by ERISA which challenges the quality of health care benefits received under the plan and, therefore, the action cannot be removed to federal court pursuant to 28 U.S.C. § 1441(b).

PARTIES TO THE PROCEEDINGS

Petitioner U.S. Healthcare, Inc. is a publicly held Pennsylvania corporation with its principal place of business at 980 Jolly Road, Blue Bell, PA. U.S. Healthcare, Inc., is a federally qualified health maintenance organization ("HMO") under the Federal HMO Act, 42 U.S.C. § 300e *et seq.*

Respondents are: Cecilia Dukes, an individual and the trustee ad litem of the estate of Darryl Dukes; and Linda and Ronald Visconti, individually and as the administrators of the estate of Serena Mary Visconti.

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No. _____

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U.S. HEALTHCARE, INC.,

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CECILIA DUKES, Trustee Ad Litem of the Estate of Darryl Dukes, Deceased,

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Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, U.S. Healthcare, Inc., respectfully prays that this Court issue a writ of certiorari to review the

judgment of the United States Court of Appeals for the Third Circuit entered in these consolidated appeals on June 19, 1995.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Court in the consolidated appeals in *Dukes v. U.S. Healthcare, Inc.*, Docket No. 94-1373 (3d Cir. 1994), and *Visconti by Visconti v. U.S. Healthcare*, Docket No. 94-1661 (3d Cir. 1994), is reported at *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995). The decisions of the United States District Court for the Eastern District of Pennsylvania are reported at *Dukes v. U.S. Healthcare, Inc.*, 848 F.Supp. 39 (E.D.Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir. 1995), and at *Visconti by Visconti v. U.S. Healthcare*, 857 F.Supp. 1097 (E.D.Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir. 1995).

JURISDICTION

Petitioner U.S. Healthcare, Inc., seeks to invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) to review by writ of certiorari the Order of the United States Court of Appeals for the Third Circuit dated June 19, 1995, which reversed the trial court decisions and remanded the actions with instructions to remand to state court. Pursuant to Supreme Court Rule 13.1, this petition was filed timely within 90 days of the date of Court of Appeals judgment.

STATUTORY PROVISIONS

1. 29 U.S.C. § 1441(b):

> (b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

2. Section 502(a)(1) to (4) of ERISA, 29 U.S.C. § 1132(a)(1) to (4):

> **(a) Persons empowered to bring a civil action.**
>
> A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109];
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress

such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of Section 105(c) [29 USCS § 1025(c)];

3. Section 514(a) of ERISA, 29 USC § 1144(a):

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

STATEMENT OF THE CASE

These consolidated actions examine the scope of federal court removal jurisdiction over state court actions brought by participants or beneficiaries in employee benefit plans governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). Petitioner U.S. Healthcare Inc. ("U.S. Healthcare"), operates a federally qualified health maintenance organization ("HMO"). Pursuant to its contracts with employers, U.S. Healthcare administers and arranges for health care services for employees pursuant to employee benefit plans established under ERISA. U.S. Healthcare is not a medical provider; U.S. Healthcare instead arranges for health care services rendered to plan beneficiaries by

independent physicians and other health care providers in the providers' own offices or facilities.

In each of these consolidated actions, the respondents' only relationship to U.S. Healthcare is that of a participant or beneficiary in an employee benefit plan. Respondents Linda and Ronald Visconti are the parents of Serena Visconti, who was stillborn on August 29, 1991, as a result of the alleged negligence of Mrs. Visconti's obstetrician/gynecologist. Respondent Cecilia Dukes is the widow of Darryl Dukes, who died as a result of the alleged negligence of his treating physicians. Mrs. Visconti and Mr. Dukes received medical benefits through employee benefit plans established by their employers under ERISA.

As a result of the alleged negligence of their treating physicians, respondents filed state court medical malpractice actions against those physicians and U.S. Healthcare. Because U.S. Healthcare is not a medical service provider, respondents sought to recover damages from it based on the manner in which it structured, maintained and administered the delivery of health care benefits under the ERISA plan and to hold U.S. Healthcare vicariously liable for the alleged negligence of their treating physicians.

U.S. Healthcare timely removed the actions to the United States District Court for the Eastern District of Pennsylvania pursuant to 28 U.S.C. § 1441(b). In each case, U.S. Healthcare moved to dismiss the complaint, arguing that ERISA completely preempted respondents' state law claims.

On March 17, 1994, the United States District Court for the Eastern District of Pennsylvania dismissed the *Dukes* action and remanded to state court the remaining state law claims against Mr. Dukes' physicians and hospitals. App. at 43a. The district court found that Section 514(a) of ERISA preempted respondents' claims of direct liability against U.S. Healthcare. "A claim based on the allegations of direct negligence . . . would involve an examination of how the plan is operated; how USHC chooses its doctors and hospitals, how USHC decides with which doctors and hospitals it will affiliate, whether the doctors are employees of USHC subject to USHC's control or independent contractors." These claims, "involving USHC's administration of the benefit plan," relate to the plan and are preempted by Section 514(a) of ERISA. App. at 38a, n.4. Similarly, respondents' claim of vicarious liability "is one relating plan performance to plan-promise, and is therefore preempted by ERISA." App. at 40a.

On June 8, 1994, the United States District Court for the Eastern District of Pennsylvania issued a comprehensive written opinion which granted U.S. Healthcare's motion to dismiss the *Visconti* complaint. App. at 44a to 60a. Relying on *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), the court recognized an exception to the well-pleaded complaint rule when Congress so completely preempts an area of federal concern that any complaint raising this type of claim is necessarily federal in character. "[B]ecause the enforcement provisions of ERISA concern similar issues and policies as those addressed by Plaintiffs' cause of action," the district court concluded that "the defense . . . of preemption pursuant to ERISA

constitutes an exception to the well-pleaded complaint rule and forms a basis for removal". App. at 49a. The District Court held that Section 514(a) of ERISA pre-empted respondents' state law claims because they "relate to" an employee benefit plan under ERISA. App. at 57a to 60a.

On appeal, the Third Circuit reversed and held that the "complete preemption" doctrine of *Metropolitan Life* did not apply and the district courts lacked removal jurisdiction under 29 U.S.C. § 1441(b). App. at 4a. In reaching its decision, the Third Circuit drew a distinction for removal purposes between state law claims which are preempted by Section 514(a) of ERISA and those which are completely preempted because they fall within the scope of Section 502(a) of ERISA. Section 514(a) preempts broadly any and all claims that "relate to" an employee benefit plan. "The *Metropolitan Life* complete-preemption exception, on the other hand, is concerned with a more limited set of state laws, those which fall within the scope of ERISA's civil enforcement provision, § 502." App. at 18a. Even though they may be preempted by Section 514(a), those state law claims not within the scope of Section 502 do not provide a basis for removal under the complete preemption doctrine. *Id.*

Because respondents are beneficiaries with standing to bring an action under Section 502(a), the Third Circuit was forced to exclude certain classes of claims brought by beneficiaries from the scope of Section 502(a) to reach its conclusion that the complete preemption doctrine did not apply. The Third Circuit explained that to determine whether a participant's state law claims in any case fall within Section 502(a), a court must first determine

whether those claims challenge the availability of benefits under a plan. The Third Circuit found that the respondents' state law claims in these cases were not within Section 502(a) because they "merely attack[ed] the **quality** of the benefits they received. . . . " App. at 16a to 17a (emphasis added). "Instead of claiming that the welfare plans in any way withheld some **quantum** of benefits due, the [respondents] complain[ed] about the low **quality** of the medical treatment that they actually received. . . . " App. at 17a (emphasis added).

REASONS FOR GRANTING THE WRIT

This case presents an opportunity for this Court to define the scope of removal jurisdiction over state court actions brought by participants or beneficiaries of employee benefit plans under ERISA, and to establish the right of beneficiaries and plans to have these ERISA claims heard in federal courts applying federal law. Since this Court's decision in *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987), the task of defining the scope of federal removal jurisdiction in ERISA cases has divided the Courts of Appeal, and even panels within particular circuits. As the task of providing employee health care benefits becomes increasingly complex and state law claims proliferate, this Court must establish firmly the scope of federal jurisdiction over claims brought by beneficiaries of ERISA plans.

The Complete Preemption Doctrine In ERISA Cases

These cases involve claims brought by beneficiaries of employee benefit plans under ERISA. "ERISA sets out a comprehensive system for the federal regulation of private employee benefit plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 582 (1992). Section 502(a) of ERISA, 29 U.S.C. § 1132(a), provides an exclusive, federal enforcement scheme for claims by plan beneficiaries, like respondents. Under Section 502(a), a plan beneficiary may sue to recover benefits, to enforce or clarify rights under a plan, to redress breaches by those ERISA fiduciaries who exercise discretionary control in the administration of a plan, or to enforce any provision of ERISA. The relief entered may include an award of accrued benefits, a declatory judgment, an injunction, or any appropriate equitable relief. 29 U.S.C. § 1132(a); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 41, 53 (1987). These civil remedies cannot be supplemented or supplanted by state common law claims. *Id.* at 54.

In order to maintain the integrity of its regulatory and enforcement scheme, Section 514(a) of ERISA, 29 U.S.C. § 1144(a), establishes as an area of exclusive federal concern any state law that relates to an employee benefit plan governed by ERISA. Section 514(a) provides that with certain exceptions not relevant to these cases "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a).

Although Section 502(e) of ERISA, 29 U.S.C. § 1132(e), grants federal courts jurisdiction over actions

brought by participants, the existence of federal question jurisdiction ordinarily is determined from the allegations of the plaintiff's well-pleaded complaint. A cause of action "arises under" federal law, and removal is proper, only when a federal question is presented on the face of the plaintiff's properly pleaded complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 9-12 (1983).

This Court has recognized an exception to the well-pleaded complaint rule in those instances in which Congress has "so completely preempt[ed] a particular area that any civil action raising this select group of claims is necessarily federal in character" and any such claim is purely a creature of federal law. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 63-64. In *Metropolitan Life*, this Court examined whether state common law claims for the alleged improper processing of benefits brought by beneficiaries of employee benefit plans governed by ERISA are removable to federal court under 28 USC § 1441(b). *Id.*, at 60. After examining the Congressional purposes underlying ERISA, this Court concluded that Congress has clearly manifested an intent to allow removal of state court actions brought by ERISA plan beneficiaries that are within the scope of the civil enforcement provisions of Section 502(a). *Id.*, at 66-67.

Conflicts Among The Circuits Over The Scope Of Removal Jurisdiction In ERISA Cases

Since this Court's decision in *Metropolitan Life*, the task of defining the scope of removal jurisdiction in ERISA-related actions has perplexed and divided the

Courts of Appeal. Several Courts of Appeal, like the Third Circuit in *Dukes*, have recognized a distinction for removal purposes between state law causes of action preempted by Section 514(a) and those causes of action which seek remedies provided by Section 502(a) of ERISA. For example, in *Alexander v. Electronic Data Systems Corp.*, 13 F.3d 940 (6th Cir. 1994), the Sixth Circuit specifically refused "to interpret *Metropolitan Life* as conferring federal question jurisdiction whenever an ERISA preemption defense is raised; regardless of whether the defense is premised on § 1132, § 1144 or some other section." *Id.*, at 944. The court instead concluded that "a defense premised on § 1132 preemption creates federal question jurisdiction, but that one based on § 1144 preemption does not." *Id.* at 945.[1] These Courts of Appeal restrict removal jurisdiction to causes of action which seek remedies available under Section 502(a). *See Zuniga v. Blue Cross and Blue Shield of Michigan*, 52 F.3d 1395, 1398 (6th Cir. 1995); *Warner v. Ford Motor Co.*, 46 F.3d 531, 534 (6th Cir. 1995); *Lupo v. Human Affairs International, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994).

Other Courts of Appeal, relying on *Metropolitan Life*, have defined the scope of removal jurisdiction by reference to Section 514(a) of ERISA. *Hubbard v. Blue Cross & Blue Shield Association*, 42 F.3d 942, 944 (5th Cir.), *cert. denied, Blue Cross & Blue Shield v. Hubbard*, ___ U.S. ___, 115 S. Ct. 2276 (1995) ("Because ERISA preemption is so comprehensive, it can provide a sufficient basis for

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[1] The Sixth Circuit recognized that its interpretation of *Metropolitan Life* was not in accord with that of other courts deciding this issue. 13 F.3d at 945 n.6.

removal to federal court even though it is raised as a defense, notwithstanding the 'well-pleaded complaint' rule."); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 508 (10th Cir. 1991) ("[I]n *Metropolitan Life* . . . , the Court held that an action alleging only state law claims is removable to federal court if it gives rise to the defense of ERISA preemption."); *see McCoy v. Massachusetts Institute of Technology*, 950 F. 2d 13, 14 n.1 (1st Cir. 1991), *cert. denied*, 504 U.S. 910 (1992). Under these decisions, "the language of section 1144, establishing the scope of ERISA preemption, also establishes the scope of ERISA jurisdiction . . . [for] a common legislative intent underlies sections 1132 and 1144." *Stevens v. Employer - Teamsters Joint Council No. 84 Pension Fund*, 979 F.2d 444, 450 (6th Cir. 1992); *see Shiffler v. The Equitable Life Assurance Society of the United States*, 838 F.2d 78, 81 (3d Cir 1988) ("Determination of whether there is federal court jurisdiction requires us to consider the preemptive effect of ERISA found in 29 U.S.C. § 1144(a)."); *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1422 (9th Cir.), *cert. denied*, 504 U.S. 986 (1992) (removal jurisdiction under Section 514, even though plaintiff did not assert claims under Section 502). In contrast to *Dukes*, under these courts decisions, a beneficiary's state cause of action against his HMO for an alleged failure to provide "prompt and adequate medical care and coverage" may be removed without reference to Section 502(a) of ERISA. *Rodriguez v. Pacificare of Texas, Inc.*, 980 F. 2d 1014, 1016 (5th Cir.), *cert. denied*, ___ U.S. ___, 113 S. Ct. 2456 (1993).

The distinction drawn by the Third Circuit between participant claims challenging the "quantum" of benefits

and those challenging the "quality" of benefits also conflicts with the decision of the Fifth Circuit in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). In *Corcoran*, the Fifth Circuit exercised removal jurisdiction and held that ERISA preempted the plaintiff's state court malpractice claims against United, an administrative group which performed utilization review for the plan. 965 F.2d at 1323-24. Congress "enacted a preemption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits **against entities so integrally connected with a plan.**" *Id.* at 1334 (emphasis added).

The Third Circuit distinguished the decision in *Corcoran* because United performed "an administrative function inherent in the 'utilization review' " and was in a position to deny benefits under the plan. U.S. Healthcare, on the other hand, merely "arranged for" the delivery of benefits under the plan, a role played by Blue Cross in *Corcoran*. App. at 27a to 28a. But this distinction between plan administrative functions is found nowhere in ERISA and was not material to the decision in *Corcoran*. Indeed, the Fifth Circuit did not reach this issue because the plaintiff abandoned its claims against Blue Cross after they were dismissed by the trial court. 965 F.2d at 1326.

This Court Should Grant Certiorari To Resolve The Conflicts Among The Circuits And To Define The Scope Of Removal Jurisdiction Over Actions Brought By ERISA Plan Beneficiaries

This case presents an opportunity for this Court to resolve the conflict among the Courts of Appeal and to

define properly the scope of removal jurisdiction under *Metropolitan Life* in actions brought by participants or beneficiaries under an employee benefit plan governed by ERISA. This Court "has not yet had an opportunity to explain further . . . or to distinguish carefully between ordinary preemption and 'complete preemption.'" *Warner v. Ford Motor Co.*, 46 F.3d at 534. By issuing a writ of certiorari, in this case, this Court may resolve the conflicts among the Courts of Appeal and firmly establish the scope of federal jurisdiction over claims brought by ERISA plan beneficiaries.

The availability of a federal forum to participants and to plan administrators assumes greater importance as the task of providing health care benefits grows increasingly complex. In enacting ERISA, Congress clearly contemplated a wide variety of means to deliver benefits to participants. 29 U.S.C. § 1002(1). As medical costs have increased, employee benefit plans have adopted a number of programs to deliver benefits efficiently and maintain incentives to employer participation. These programs include precertification procedures, designated provider networks, prepaid medical services, 42 U.S.C. § 300e-1(a) & (b), and other cost containment provisions. *See Corcoran*, 965 F.2d at 1327, 1331.

The Third Circuit's attempt to distinguish between these legitimate administrative functions and restrict access to federal court to only those claims which involve the simple denial of benefits threatens the integrity of the comprehensive enforcement scheme enacted by Congress and conflicts with Supreme Court precedent which define the scope of Section 502(a). Because the establishment

and administration of employee benefit plans is not limited to the mere determination of benefit eligibility, the scope of federal court jurisdiction over participant claims under ERISA cannot be limited to actions for the denial of benefit claims. To avoid Section 502(a), however, the Third Circuit distinguished participants' claims which challenge the "quantum" of benefits from those which attack the "quality" of benefits received. Whatever the feasibility of this distinction, (for respondents' claims certainly relate "plan performance to plan-promise", App. at 40a), this Court has rejected it as a basis for defining the scope of federal court jurisdiction under Section 502(a). In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), this Court recognized that Congress intended Section 502(a) to be the exclusive method by which participants could define and enforce their rights under an ERISA Plan. *Id* at 143. Section 502(a) is not only the exclusive method for vindicating protected rights under ERISA "but there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek 'pension benefits'." *Id.*, at 146; *see Anderson v. Electronic Data Systems Corp.*, 11 F.3d 1311, 1315 n.6 (5th Cir.), *cert. denied*, ___ U.S. ___, 115 S. Ct. 55 (1994) ("Section 502(a) is not confined to enforcing claims for benefits due under ERISA plans.").

While Section 502(a) grants participants standing to enforce their rights and expectations under employee benefit plans, the Third Circuit's decision is motivated by a concern that Congress failed to provide them with the full range of remedies available under state law. The Third Circuit explained that nothing "in the legislative history, structure, or purpose of ERISA suggest[s] that

Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice." App. at 18a. But the absence of a remedy does not affect the jurisdictional analysis under ERISA. "[A] finding of preemption [under Section 502(a)] does not hinge on whether ERISA provides the remedy the plaintiff seeks or any remedy at all." *Anderson v. Electronic Data Systems Corp.*, 11 F.3d at 1314. Congress intended Section 502(a) to be the exclusive means by which participants may define and enforce their rights and expectations under employee benefit plans. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 54.

By issuing a writ of certiorari in this case, this Court can determine finally whether federal courts applying federal law will define a participant's right and expectations under an employee benefit plan governed by ERISA. State common law causes of action like those brought by respondents seek to define a participant's rights and impose standards of conduct on ERISA plans through the imposition of damages. " 'The obligation to pay compensation can be, indeed, is designed to be, a potent method of governing conduct and controlling policy.' " *Cipollone v. Leggett Group, Inc.*, 112 S. Ct. 2608, 2620 (1992), *quoting, San Diego Bldg. Trades Council v. Gorman*, 396 U.S. 236, 247 (1959). But as this Court held in *McClendon*, Congress intended Section 502(a) to be the sole means by which participants could define their rights and remedies under a plan. While "Congress perhaps could

not have predicted the interjection of [cost containment programs] into the ERISA 'system' . . . , it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute" to allow state common law to dictate a participant's rights and remedies under an employee benefit plan. *Corcoran*, 965 F.2d at 1334.

CONCLUSION

For all the reasons stated, Petitioner U.S. Healthcare, Inc., prays that this Court grant a writ of certiorari to review the decision of the United States District Court of Appeals for the Third Circuit.

Respectfully submitted,

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Filed June 19, 1995

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 94-1373

CECILIA DUKES, Trustee Ad Litem of the Estate of
Darryl Dukes, Deceased,
Appellant

v.

U.S. HEALTHCARE, INC.; GERMANTOWN HOSPITAL
& MEDICAL CENTER; WILLIAM W. BANKS, M.D.;
CHARLES R. DREW MENTAL HEALTH CENTER;
EDWARD B. HOSTEN, M.D.

On Appeal From the United States District Court For
the Eastern District of Pennsylvania
(D.C. Civil Action No. 93-cv-00577)

NO. 94-1661

SERENA MARY VISCONTI, DECEASED, BY LINDA
AND RONALD VISCONTI, AS ADMINISTRATORS OF
THE ESTATE OF SERENA MARY VISCONTI,
DECEASED; LINDA VISCONTI; RONALD VISCONTI,
IN THEIR OWN RIGHT,
Appellants

v.

U.S. HEALTH CARE, a/k/a
THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA/NJ

On Appeal From the United States District Court
For the Eastern District of Pennsylvania
(D.C. Civil Action No. 93-cv-06495)

Argued December 5, 1994

BEFORE: STAPLETON, ROTH and LEWIS,
Circuit Judges

(Opinion Filed June 19, 1995)

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OPINION OF THE COURT

STAPLETON, *Circuit Judge:*

The plaintiffs in these two cases filed suit in state court against health maintenance organizations ("HMOs") organized by U.S. Healthcare, Inc., claiming

damages, under various theories, for injuries arising from the medical malpractice of HMO-affiliated hospitals and medical personnel. The defendant HMOs removed both cases to federal court, arguing (1) that the injured person in each case had obtained medical care as a benefit from a welfare-benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001-1461 (1988), (2) that removal is proper under the *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), "complete preemption" exception to the "well-pleaded complaint rule," and (3) that the plaintiffs' claims are preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a). The district courts agreed with these contentions and dismissed the plaintiffs' claims against the HMOs. The plaintiffs appeal those rulings and ask that their claims against the HMOs be remanded to state court.

We hold that on the record before us, the plaintiffs' claims are not claims "to recover [plan] benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan" as those phrases are used in § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). Accordingly, we hold that *Metropolitan Life's* "complete preemption" exception is inapplicable and that removal of these claims from state court was improper. We will reverse the judgments of the district courts and will remand each case to district court with instructions to remand the cases to the state courts from which they were removed.

I.

A.

Suffering from various ailments, Darryl Dukes visited his primary care physician, defendant Dr. William W. Banks, M.D., who identified a problem with Darryl's ears. A few days later, Banks performed surgery and prepared a prescription ordering that blood studies be performed. Darryl presented that prescription to the laboratory of Germantown Hospital and Medical Center but the hospital refused to perform the tests. The record does not reveal the reasons for the hospital's refusal.

The next day, Darryl sought treatment from defendant Dr. Edward B. Hosten, M.D. at the Charles R. Drew Mental Health Center, who also ordered a blood test. This time, the test was performed. Darryl's condition nevertheless continued to worsen and he died shortly thereafter. Darryl's blood sugar level was extremely high at the time of his death. That condition allegedly would have or could have been diagnosed through a timely blood test.

Darryl received his medical treatment through the United States Health Care Systems of Pennsylvania, Inc., a federally qualified health maintenance organization organized by U.S. Healthcare. As a qualified HMO under the federal Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-300e-17 (1988), this U.S. Healthcare HMO provides basic and supplemental health services to its members on a pre-paid basis.[1] As is often the case,

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[1] HMOs often contain costs through a strategy known as "utilization review." *See generally* John D. Blum, *An Analysis of*

Darryl received his membership in the HMO through his participation in an ERISA-covered welfare plan sponsored by his employer.

Darryl's wife, Cecilia Dukes, brought suit in state court alleging medical malpractice and other negligence against numerous defendants, including Banks, Hosten, the Germantown Hospital, and the Drew Center. She also brought suit against the HMO, alleging that as the organization through which Darryl received his medical treatment, it was responsible, under a Pennsylvania state law ostensible agency theory (the "agency theory"), for the negligence of the various doctors and other medical-service providers. *See Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229, 1234-35 (Pa.Super.Ct. 1988) (holding that an HMO may be held liable for malpractice under an ostensible agency theory where a patient looks to the HMO for care and the HMO's conduct leads the patient to reasonably believe that he or she is being treated by an employee of the HMO). She alleged further that the HMO failed to exercise reasonable care in selecting, retaining, screening, monitoring, and evaluating the personnel who

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Legal Liability in Health Care Utilization Review and Case Management, 26 Hous.L.Rev. 191, 192-93 (1989); Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 Colum.L.Rev. 1674, 1677-83 (1994). Unlike traditional insurance policies, HMOs usually decide whether to reimburse patients for medical care prospectively – through utilization or "pre-certification" review. The HMO may either perform the utilization review itself or assign the task to a third-party contractor. *Id.* at 1681; *see also Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1323 (5th Cir.), *cert. denied*, 113 S.Ct. 812 (1992).

actually provided the medical services (the "direct negligence theory").

The HMO removed the case to district court pursuant to the *Metropolitan Life* complete-preemption exception to the "well-pleaded complaint rule." In its notice of removal, it claimed that the HMO is part of – or at least plays a role in – the ERISA plan to provide health benefits and that Dukes' claims, properly construed, "are directed to the structure and operation of the employer benefit plan." (*Dukes* app. at 31.) In its view, Dukes' claims therefore "relate to" the welfare plan and accordingly are preempted under ERISA § 514(a), 29 U.S.C. § 1144(a).

Dukes moved for a remand and the HMO moved to dismiss. The district court denied Dukes' motion and granted the HMO's, explaining that Dukes' claims "related to" an ERISA plan – and thus were preempted – because (1) "any ostensible agency claim must be made on the basis of what the benefit plan provides and is therefore 'related' to it" and (2) "the treatment received must be measured against the benefit plan and is therefore also 'related' to it." *Dukes v. United States Health Care Sys., Inc.*, 848 F.Supp. 39, 42 (E.D.Pa. 1994). It remanded to state court the remainder of Dukes' claims against the other defendants. *Id.* at 43.

B.

Ronald and Linda Visconti are the biological parents of Serena Visconti, who was stillborn. During the third trimester of her pregnancy with Serena, Linda apparently developed symptoms typical of preeclampsia. The Viscontis claim that Linda's obstetrician, Dr. Wisniewski,

negligently ignored these symptoms and that this negligence caused Serena's death.

Like Darryl Dukes, Linda received her medical treatment through a federally qualified HMO organized by U.S. Healthcare. This HMO was called the Health Maintenance Organization of Pennsylvania/New Jersey. The Viscontis received their membership in the HMO through an ERISA-covered welfare plan.

Ronald Visconti, as administrator of Serena's estate, and Ronald and Linda, in their own right (collectively, "the Viscontis"), brought suit in the Philadelphia County Court of Common Pleas. They attempted to hold the HMO liable for Dr. Wisniewski's malpractice under ostensible and actual agency theories, alleging that when Linda became pregnant, the HMO held out Dr. Wisniewski as a competent and qualified participating obstetrician/gynecologist. They also sued the HMO under a direct negligence theory, claiming, among other things, that the HMO was negligent in its selection, employment, and oversight of the medical personnel who performed the actual medical treatment.

The HMO removed the case to federal court, asserting that the Viscontis' claims were completely preempted by ERISA. It then filed a motion to dismiss, and the Viscontis filed a motion to remand, contending that removal was improper and that ERISA did not preempt their state law claims. The district court denied the Viscontis' motion but granted the HMO's motion to dismiss. *Visconti ex rel. Visconti v. U.S. Health Care*, 857 F.Supp. 1097, 1105 (E.D.Pa. 1994).

The *Visconti* and *Dukes* cases have been consolidated on appeal.

II.

The HMOs removed these cases to federal court pursuant to 28 U.S.C. § 1441, alleging that the district courts had original jurisdiction over the claims, because the claims "[arose] under the Constitution, treaties or laws of the United States." § 1441(b); 28 U.S.C. § 1331. To determine whether a claim "arises under" federal law – and thus is removable – we begin with the "well-pleaded complaint rule." *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987); *see also Allstate Ins. Co. v. 65 Security Plan*, 879 F.2d 90, 92-93 (3d Cir. 1989).

Under the well-pleaded complaint rule, a cause of action "arises under" federal law, and removal is proper, only if a federal question is presented on the face of the plaintiff's properly pleaded complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 9-12 (1983). A federal defense to a plaintiff's state law cause of action ordinarily does not appear on the face of the well-pleaded complaint, and, therefore, usually is insufficient to warrant removal to federal court. *Gully v. First Nat'l Bank*, 299 U.S. 109, 115-18 (1936). Thus, it is well-established that the defense of preemption ordinarily is insufficient justification to permit removal to federal court. *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 398 (1987) ("The fact that a defendant might ultimately prove that a plaintiff's claims are pre-empted under [a federal statute] does not establish that they are removable to federal court.").

The Supreme Court has recognized an exception to the well-pleaded complaint rule – the "complete preemption" exception – under which "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life*, 481 U.S. at 63-64; *see generally Goepel v. National Postal Mail Handlers Union*, 36 F.3d 306, 309-13 (3d Cir. 1994) (discussing the Court's complete-preemption jurisprudence and holding that the Federal Employees Health Benefits Act did not completely pre-empt plaintiffs' state law claims), *cert. denied*, 131 L.Ed.2d 555 (1995); *Allstate*, 879 F.2d at 93-94 (holding that the complete-preemption exception did not apply in a situation where an insurance company plaintiff sought contribution from an ERISA plan because § 502 of ERISA does not provide an express cause of action vindicating the interest that the suit sought to protect and enforce); *Railway Labor Executives Ass'n v. Pittsburgh & Lake Erie R.R. Co.*, 858 F.2d 936, 939-43 (3d Cir. 1988) (discussing the Court's complete-preemption doctrine and holding that neither the Railway Labor Act nor the Interstate Commerce Act completely preempted plaintiffs' state law fraudulent conveyance claims against railroads and railroad officials). The complete preemption doctrine applies when

> the pre-emptive force of [the federal statutory provision] is so powerful as to displace entirely any state cause of action [addressed by the federal statute]. Any such suit is purely a creature of federal law, notwithstanding the fact that state law would provide a cause of action in the absence of [the federal provision].

Franchise Tax Bd., 463 U.S. at 23. Claims to enforce a collective-bargaining agreement under § 301 of the Labor Management Relations Act of 1947, 29 U.S.C. § 185, present a typical example of the complete-preemption doctrine at work: In *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), the Court ruled that any claims to enforce a collective-bargaining agreement – even when phrased as a state law cause of action to enforce a contract – are removable to federal court.

The Supreme Court has determined that Congress intended the complete-preemption doctrine to apply to state law causes of action which fit within the scope of ERISA's civil-enforcement provisions.[2] *Metropolitan Life*, 481 U.S. at 66. It explained:

> [T]he legislative history consistently sets out [Congress's] clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of [the Labor Management Relations Act of 1947, 29 U.S.C. § 185.] For example, Senator

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[2] ERISA's "six carefully integrated civil enforcement provisions" are found in § 502. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). The statutory provision relevant for the purposes of this appeal, § 502(a)(1)(B), states in pertinent part:

> (a) **Persons empowered to bring a civil action**
> A civil action may be brought –
> (1) by a participant or beneficiary –
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . .

> Williams, a sponsor of ERISA, emphasized that the civil enforcement section would enable participants and beneficiaries to bring suit to recover benefits denied contrary to the terms of the plan and that when they did so "[i]t is intended that such actions will be regarded as arising under the laws of the United States, in a similar fashion to those brought under section 301 of the Labor Management Relations Act."

481 U.S. at 66 (citations omitted). Thus, courts have found that the *Metropolitan Life* complete-preemption doctrine permits removal of state law causes of action in a host of different ERISA-related circumstances. *See id.* at 63-67 (holding that state common law causes of action asserting improper processing of a claim for benefits under an employee benefit plan are removable to federal court); *Anderson v. Electronic Data Sys. Corp.*, 11 F.3d 1311, 1314 (5th Cir.) (holding that removal was proper because state law claim alleging that plan fiduciary was demoted and terminated for refusing to violate ERISA fell within § 502(a)(2) & (3)), *cert. denied*, 115 S.Ct. 55 (1994); *Sofo v. Pan-American Life Ins. Co.*, 13 F.3d 239, 240-41 (7th Cir. 1994) (plaintiff's state court rescission claim against a group insurance policy for the policy's refusal to reimburse plaintiff for medical treatment received was properly removed because plaintiff's claim was for a denial of benefits); *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 8-12 (2d Cir. 1992) (common law claim for breach of an oral promise to pay pension-related benefits properly removed to federal court); *Lister v. Stark*, 890 F.2d 941, 943-44 (7th Cir.

1989) (plaintiff's state law claim challenging the calculation of his time of "uninterrupted service" for the purposes of calculating his pension benefits held removable), *cert. denied*, 498 U.S. (1990).

That the Supreme Court has recognized a limited exception to the well-pleaded complaint rule for state law claims which fit within the scope of § 502 by no means implies that all claims preempted by ERISA are subject to removal. Instead, as the U.S. Court of Appeals for the Sixth Circuit wrote recently, "[r]emoval and preemption are two distinct concepts." *Warner v. Ford Motor Co.*, 46 F.3d 531, 535 (6th Cir. 1995). Section 514 of ERISA defines the scope of ERISA preemption, providing that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in [§ 4(a) of ERISA] and not exempt under [§ 4(b) of ERISA]." (Emphasis added.) The *Metropolitan Life* complete-preemption exception, on the other hand, is concerned with a more limited set of state laws, those which fall within the scope of ERISA's civil enforcement provision, § 502. State law claims which fall outside of the scope of § 502, even if preempted by § 514(a), are still governed by the well-pleaded complaint rule and, therefore, are not removable under the complete-preemption principles established in *Metropolitan Life*. *See Franchise Tax Bd.*, 463 U.S. at 23-27 (holding that preemption under § 514(a) does not permit a defendant to remove a suit brought in state court to federal court when the plaintiff's state claim does not fall within the scope of ERISA's civil remedy provisions); *Metropolitan Life*, 481 U.S. at 64 (stating that ERISA preemption under § 514(a) "without more, does not convert [a] state claim into an action arising

under federal law"); *see also Allstate*, 879 F.2d at 93-94 (holding that § 514(a) preemption defense will not justify removal unless claim falls within the scope of ERISA's civil enforcement provision, § 502); *Warner*, 46 F.3d at 535 (that a claim is preempted under § 514(a) does not necessarily establish that the claim is removable); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272-73 (2d Cir. 1994) (state law professional malpractice claim against company hired by plaintiff's employer to provide psychotherapy services deemed outside the scope of § 502(a)(1)(B) and therefore not removable).

The difference between preemption and complete preemption is important. When the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption. It lacks power to do anything other than remand to the state court where the preemption issue can be addressed and resolved. *Franchise Tax Bd.*, 463 U.S. at 4, 27-28; *Allstate*, 879 F.2d at 94; *Warner*, 46 F.3d at 533-35; *Lupo*, 28 F.3d at 274.

III.

The district courts in these cases found that the plaintiffs' state law claims against the U.S. Healthcare HMOs fall within the scope of § 502(a)(1)(B) and that the *Metropolitan Life* complete-preemption doctrine therefore permits removal.[3] We disagree.

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[3] There is no contention that the plaintiffs' state law claims implicate any of ERISA's civil enforcement provisions other

To determine whether the state law claims fall within the scope of § 502(a)(1)(B), we must determine whether those claims, properly construed, are "to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan." In making that determination, it would be helpful to have a complete understanding in each case of the relationships among the HMO, the employer, and the other defendants, the nature of the plan benefits, and the rights of participants and beneficiaries under the plan. We are somewhat hampered here because these cases come to us on appeal from orders granting motions to dismiss. Because of this procedural status, the parties have had little chance to develop the records and, accordingly, we know very little about the nature of the plan benefits or about the role – if any – that U.S. Healthcare's HMOs play in the respective ERISA welfare plans.

We recognize that there are issues in dispute. The plaintiffs and the Department of Labor as amicus curie [sic], for example, claim that the U.S. Healthcare HMOs are separate from the ERISA plans and that the sole benefit that participants and beneficiaries receive from each plan is the plaintiffs' *membership* in the HMOs. In their view, the plaintiffs' claims thus have nothing at all to do with § 502(a)(1)(B) because no one contests that the plaintiffs in fact have received their plan benefits (their membership in the HMO). Instead, under their view, the

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than those set out in § 502(a)(1)(B). Accordingly, we direct our discussion to whether the plaintiffs' claims fall within the scope of § 502(a)(1)(B).

plaintiffs' claims merely attack the behavior of an entity completely external to the ERISA plan.

U.S. Healthcare, on the other hand, claims that the plan benefits are more than just the plan participants' or beneficiaries' memberships in the respective HMOs; it argues that *the medical care received* is itself the plan benefit. As a corollary to that position, it also disagrees with the plaintiffs' view that the HMOs are completely distinct from the respective ERISA plans, arguing that the HMOs in fact play a role in the delivery of plan benefits. It further maintains that ERISA is implicated because both the plaintiffs' agency claims and their direct negligence claims relate to the quality of the plan benefits and the HMOs' role as the entity that arranges for those benefits for the ERISA plans.

We need not here resolve these disputes about how to characterize the plan benefits or the HMOs' role in the respective ERISA plans. We will assume, without deciding, that the medical care provided (and not merely the plaintiffs' memberships in the respective HMOs) is the plan benefit for the purposes of ERISA. We will also assume that the HMOs, either as a part of or on behalf of the ERISA plans, arrange for the delivery of those plan benefits. We thus assume, for example, that removal jurisdiction would exist if the plaintiffs were alleging that the HMOs refused to provide the services to which membership entitled them.

Given those assumptions, we nevertheless conclude that removal was improper. We are compelled to this conclusion because the plaintiffs' claims, even when construed as U.S. Healthcare suggests, merely attack the

quality of the benefits they received: The plaintiffs here simply do not claim that the plans erroneously withheld benefits due. Nor do they ask the state courts to enforce their rights under the terms of their respective plans or to clarify their rights to future benefits. As a result, the plaintiffs' claims fall outside of the scope of § 502(a)(1)(B) and these cases must be remanded to the state courts from which they were removed.

A.

Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies on Darryl because the ERISA plan refused to pay for those studies. Similarly, the Viscontis do not contend that Serena's death was due to their welfare plan's refusal to pay for or otherwise provide for medical services. Instead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs in both cases complain about the low quality of the medical treatment that they actually received and argue that the U.S. Healthcare HMO should be held liable under agency and negligence principles.

We are confident that a claim about the quality of a benefit received is not a claim under § 502(a)(1)(B) to "recover benefits due . . . under the terms of [the] plan." To reach that conclusion, "we begin as we do in any exercise of statutory construction with the text of the provision in question, and move on, as need be, to the

structure and purpose of the Act in which it occurs." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, Nos. 93-1408, 93-1414, 93-1415, 1995 WL 238409, at *6 (April 26, 1995).

The text lends no support to U.S. Healthcare's argument. On its face, a suit "to recover benefits due . . . under the terms of [the] plan" is concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received.

Nor does anything in the legislative history, structure, or purpose of ERISA suggest that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice. When Congress enacted ERISA it was concerned in large part with the various mechanisms and institutions involved in the funding and payment of plan benefits. That is, Congress was concerned "that owing to the inadequacy of current minimum [financial and administrative] standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered." § 2, 29 U.S.C. § 1001(a). Thus, Congress sought to assure that promised benefits would be available when plan participants had need of them and § 502 was intended to provide each individual participant with a remedy in the event that promises made by the plan were not kept. We find nothing in the legislative history suggesting that § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants. Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied

by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such. *See, e.g., Travelers Ins. Co.*, 1995 WL 238409, at *7 (noting that while quality standards and work place regulations in the context of hospital services will indirectly affect the sorts of benefits an ERISA plan can afford, they have traditionally been left to the states, and there is no indication in ERISA that Congress chose to displace general health care regulation by the states).

B.

We also reject the HMOs' attempts to characterize the plaintiffs' state court complaints as attempts to enforce their "rights under the terms of the [respective welfare] plan[s]." That phrase is included, we believe, so as to provide a means of enforcing any contract rights other than the right to benefits, as for example the various plan-created rights of plan participants to benefit-claim and benefit-eligibility procedures. Just as § 502(a)(1)(B) provides the means by which a participant can insist on the promised benefits, so too does it provide the means for insisting on the plan-created rights other than plan benefits.[4]

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[4] ERISA ordinarily requires that welfare plans set out a description of the rights of the participants and their beneficiaries in a summary plan description ("SPD"). 29 U.S.C. § 1022(b); *see also* 29 C.F.R. § 2520.102-2(a) (the plan description must "apprise the plan's participants and beneficiaries of their rights and obligations under the plan"); 29 C.F.R. § 2520.102-3(j)(2) (SPD for an ERISA welfare plan must include "a statement of the conditions pertaining to eligibility to receive benefits"); 29 C.F.R. § 250.102-3(l) (SPD must include "a

The HMOs point to no plan-created right implicated by the plaintiffs' state law medical malpractice claims. The best they can do is assert that the plaintiffs' medical malpractice claims "attempt to define a participant's rights under the plan." (Appellee's bf. in *Visconti*, at 9.) We cannot accept that characterization. The plaintiffs are not attempting to define new "rights under the terms of the plan"; instead, they are attempting to assert their already-existing rights under the generally-applicable

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statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits"); 29 C.F.R. § 102-3(s) (SPD must include a statement describing "[t]he procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part"). That requirement is relaxed in situations where the ERISA plan chooses to provide benefits through a qualified HMO. Under 29 C.F.R. § 2520.102-5(a), if health benefits are provided through an HMO, the SPD need not contain the usual description of the rights of participants or beneficiaries, provided the SPD contains a notice stating, among other things, that plan participants will receive membership "in one or more qualified health maintenance organizations," § 2520.102-5(b)(1), and that upon request each available HMO will provide certain written information, namely

> (i) the nature of services provided to members; (ii) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and circumstances under which services may be denied; and (iii) the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part.

§ 2520.102-5(b)(3).

state law of agency and tort. Inherent in the phrases "rights under the terms of the plan" and "benefits due . . . under the terms of [the] plan" is the notion that the plan participants and beneficiaries will receive something to which they would not be otherwise entitled. But patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.

C.

Much of the above analysis also precludes us from concluding that the plaintiffs are asking the state courts to "clarify [their] rights to future benefits under the terms of the plan." As noted, there is no allegation here that the HMOs have withheld plan benefits due. Moreover, nothing in the complaints remotely resembles a request that the court clarify a right to a *future* benefit; instead, the plaintiffs' complaints center on past events.

D.

We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations like this where the benefit contracted for is health care services rather than money to pay for such services. There well may be cases in which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that

the plan participant or beneficiary has been denied benefits due under the plan. This is not such a case, however. While the Dukes complaint alleges that the Germantown Hospital committed malpractice when it decided not to perform certain blood tests, no one would conclude from that malpractice that Germantown Hospital was not acting as a health care provider when it made those decisions. Similarly, while the Viscontis claim that Dr. Wisniewski was incompetent, there is no indication that he was not performing health care services at the time he allegedly committed the malpractice charged.

We also recognize the possibility that an ERISA plan may describe a benefit in terms that can accurately be described as related to the quality of the service. Thus, for example, a plan might promise that all X-rays would be analyzed by radiologists with a prescribed level of advanced training. A plan participant whose X-ray was analyzed by a physician with less than the prescribed training might well be entitled to enforce the plan's promise through a suit under § 502(a)(1)(B) to secure a denied benefit.

Much of the HMOs' argument in these cases is at root a contention that the employer and the HMO impliedly contracted that the health care services provided would be of acceptable quality and, accordingly, that these damage suits rest on a failure to provide services of acceptable quality. Since we do not have before us the documents reflecting the agreements between the employers and the HMOs, we are not in a position to determine whether such a commitment was implicit in their respective agreements. However, the burden of

establishing removal jurisdiction rests with the defendant. *Abels v. State Farm Fire & Cas. Co.*, 770 F.2d 26, 29 (3d Cir. 1985); *see generally* 14A Charles A. Wright, et al., *Federal Practice & Procedure* § 3721, at 209-10 (1985 & Supp.1995). Accordingly, the HMO is not in a position to press this argument.

Moreover, we hasten to add that while we have no doubt that all concerned expected the medical services arranged for by the HMOs to be of acceptable quality, this seems to us beside the point. The relevant inquiry is not whether there was an expectation of acceptably competent services, but rather whether there was an agreement to displace the quality standard found in the otherwise applicable law with a contract standard.

It may well be that an employer and an HMO could agree that a quality of health care standard articulated in their contract would replace the standards that would otherwise be supplied by the applicable state law of tort. We express no view on whether an ERISA plan sponsor may thus by contract opt out of state tort law and into a federal law of ERISA contract. We will reserve that issue until a case arises presenting it.[5] Nothing in this record suggests an agreement to displace the otherwise applicable state laws of agency and tort.

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[5] It would seem to Judge Roth that, if a plan were to adopt its own standard of acceptable health care to be made available to beneficiaries, the plan should provide concurrently, through insurance or otherwise, an appropriate remedy to beneficiaries for any failure of the plan care providers to meet that standard or, in the alternative, should inform plan beneficiaries that tort law remedies for medical malpractice would not be available to them under the plan.

IV.

The HMOs take heart in a recent case, *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S.Ct. 812 (1992), in which the U.S. Court of Appeals for the Fifth Circuit held that ERISA preempts a medical malpractice claim against a medical consulting company for decisions it made as the third-party administrator of a welfare plan's "pre-certification" review program. We agree with the HMOs that under *Corcoran*, third-party private companies may, in some circumstances, play a role in an ERISA plan and that claims against such companies may fall within the scope of § 502(a). We nevertheless find *Corcoran* inapposite on the facts and claims alleged in this case.

Corcoran began as a state law wrongful death action against Blue Cross and Blue Shield of Alabama ("Blue Cross") and United Heathcare ("United"), in which Florence Corcoran charged that the defendants were responsible for the death of her unborn fetus. An employee at South Central Bell Telephone, Corcoran was a member of Bell's Medical Assistance Plan ("the Bell Plan"), a self-funded welfare-benefit plan which provides medical benefits to eligible Bell employees. The Bell Plan was administered by Blue Cross.

One provision of the plan, the "Quality Care Program" ("QCP") required plan participants and beneficiaries to obtain advance approval for certain medical procedures and overnight hospital visits. Such cost-containment programs typically are known as "utilization review" or "pre-certification review" programs. Under the QCP, once a patient's doctor recommended surgery or

hospitalization, the staff assigned to the QCP was required to perform an independent review of the patient's condition to determine both the need for the surgery and the appropriate length of hospitalization. As is often the case, the Bell Plan hired a third party – United – to perform the QCP for the Plan. *See generally* Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 Colum.L.Rev. 1694, 1677-83 (1994).

Corcoran's doctor, in response to difficulties Corcoran was experiencing with her pregnancy, recommended that Corcoran be hospitalized. As a result, Corcoran applied to the Bell Plan for disability benefits for the remainder of her pregnancy. Despite the recommendation of Corcoran's doctor, United determined that hospitalization was unnecessary, and instead authorized only 10 hours a day of home nursing care. The fetus went into distress and died during a period of time when the nurse assigned to Corcoran was not on duty. Corcoran subsequently filed suit in Louisiana state court against Blue Cross and United.

United removed the case to federal district court, claiming that Corcoran's claims were completely preempted by ERISA. The district court then granted United's motion to dismiss and Corcoran appealed.

The U.S. Court of Appeals for the Fifth Circuit ruled that ERISA preempted Corcoran's claim against United and – implicitly, at least – that Corcoran's claims were completely preempted. It explained that while United was in fact giving medical advice, it gave that advice as part of its role of making benefit determinations for the

plan. 965 F.2d at 1331. Thus, the court determined that plaintiffs were "attempting to recover for a tort allegedly committed in the course of handling a benefit determination," *id.* at 1332, and that such state law claims are preempted by ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (common law cause of action arising from "improper processing of a claim for benefits" preempted by ERISA); *see also Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993) (medical malpractice claim against plan administrator for delaying pre-certification of heart surgery arose from administration of benefits and therefore was preempted), *cert. denied*, 114 S.Ct. 694 (1994); *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 923 (3d Cir. 1990) (claim against plan sponsor for misrepresenting available benefits preempted), *cert. denied*, 499 U.S. 920 (1991).

The HMOs argue that we should read *Corcoran* broadly to hold that medical malpractice claims against an HMO should be removable under *Metropolitan Life* whenever an HMO provides the complained-about medical treatment as a benefit of an ERISA-covered health plan. They note that several district courts have adopted versions of their suggested approach. *See, e.g., Ricci v. Gooberman*, 840 F.Supp. 316, 317-18 (D.N.J. 1993) (plaintiff's attempt to hold an HMO liable under a vicarious liability claim similar to the ones at bar held preempted); *Butler v. Wu*, 853 F.Supp. 125, 129-30 (D.N.J. 1994) (same); *Nealy v. U.S. Healthcare HMO*, 844 F.Supp. 966, 973 (S.D.N.Y. 1994) (plaintiff's attempts to hold an HMO liable under several common law theories held preempted); *Altieri v. Cigna Dental Health, Inc.*, 753 F.Supp. 61, 63-65 (D.Conn. 1990) (ERISA preempts plaintiff's negligent

supervision claim against an HMO). *But see Independence HMO, Inc. v. Smith*, 733 F.Supp. 983, 987-89 (E.D.Pa. 1990) (ERISA does not preempt medical malpractice-type claims brought against HMOs under a vicarious liability theory); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290-91 (E.D.Pa. 1992) (same for a claim against an HMO for the HMO's negligence in selecting, retaining, and evaluating plaintiff's primary-care physician). *See also Kearney v. U.S. Healthcare, Inc.*, 859 F.Supp. 182, 186-87 (E.D.Pa. 1994) (holding in a case similar to those at bar that ERISA preempts plaintiff's direct negligence claim, but not its vicarious liability claim).

The HMOs' reliance on *Corcoran* is misplaced. Although United's decisions in *Corcoran* were in part medical decisions, United, unlike the HMOs here, did not provide, arrange for, or supervise the doctors who provided the actual medical treatment for plan participants. (Blue Cross played that role in *Corcoran*.) Instead, United only performed an administrative function inherent in the "utilization review." The difference between the "utilization review" and the "arranging for medical treatment" roles is crucial for the purposes of § 502(a)(1)(B) because only in a utilization-review role is an entity in a position to deny benefits due under an ERISA welfare

plan.[6] 965 F.2d at 1333 n. 16 (noting that ERISA is implicated in "utilization review" decisions but not medical-treatment decisions because only the former are "made in connection with a cost containment plan"); *see also Kuhl*, 999 F.2d at 301-03 (malpractice claims against insurance company hired to perform a "pre-certification review" held to fall within § 502(a)'s civil enforcement provisions); *Elsesser*, 802 F.Supp. at 1290-91 (holding that the cause of action based on allegations that HMO *withheld* benefits were preempted, while the claims against HMO for its negligent selection, retention, and evaluation of a primary-care physician were not preempted).

In these cases, the defendant HMOs play two roles, not just one.[7] In addition to the utilization-review role played by United in *Corcoran*, the HMOs also arrange for the actual medical treatment for plan participants. Only this second role is relevant for this appeal, however: on the faces of these complaints there is no allegation that the HMOs somehow should be held liable for any decisions they might have made while acting in their utilization-review roles.[8] Stated another way, unlike *Corcoran*,

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[6] As noted in Part III, we are assuming, without deciding, that the medical care provided (and not merely the plaintiffs' memberships in the respective HMOs) is the plan benefit for the purposes of ERISA. So viewed, when acting in their utilization-review role, the HMOs are making benefit determinations.

[7] There is nothing unusual about this. HMOs often arrange for the medical treatment *and* perform the utilization review (instead of hiring a third party). *See, e.g., Elsesser*, 802 F.Supp. at 1290-91 (HMO playing both roles); *see also* Stayn, *supra*, at 1677.

[8] The only possible exception is Dukes' allegation that the Germantown Hospital refused to perform blood studies on Dar-

there is no allegation here that the HMOs denied anyone any benefits that they were due under the plan. Instead, the plaintiffs here are attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment.

For this reason, these cases are more like *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994). There, an employer had contracted with a psychotherapy service group, Human Affairs International, Inc. ("HAI"), to provide mental health services to its employees in connection with an employee benefit plan governed by ERISA. Lupo, an employee who received psychotherapy services from HAI, sued HAI in a state court for his therapist's professional malpractice, breach of fiduciary duty, and intentional infliction of emotional distress. HAI, like the HMOs here, removed the case to federal court, claiming that ERISA completely preempted Lupo's claims. The district court agreed with HAI, and, accordingly, dismissed Lupo's claim. The U.S. Court of Appeals for the Second Circuit reversed, holding that the district court lacked removal jurisdiction and was thus obligated to remand to the state court. It reached this conclusion because "[o]n their face, none of [Lupo's] claims [bore] any significant resemblance to those described in [§ 502(a)(1)(B)]." 28 F.3d at 272. The situation in the cases at bar is closely analogous. As in *Lupo*, the plaintiffs' claims in these cases do not concern a denial of benefits due or a denial of some other plan-created right. Thus,

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ryl. Still, on the record before the court, there is no indication that the hospital refused to perform those studies because of the ERISA plan's refusal to pay.

the claims here, like those in Lupo, bear no significant resemblance to the claims described in § 502(a)(1)(B).

V.

For the foregoing reasons, the district courts' judgments in these cases will be reversed and remanded with instructions to remand the cases to the state courts from which they came. Our holding that the districts courts lack removal jurisdiction, of course, leaves open for resolution by the state courts the issue of whether the plaintiffs' claims are preempted under § 514(a).

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 94-1373

CECILIA DUKES, Trustee Ad Litem of the Estate of
Darryl Dukes, Deceased,
Appellant

v.

U.S. HEALTHCARE, INC.; GERMANTOWN HOSPITAL
& MEDICAL CENTER; WILLIAM W. BANKS, M.D.;
CHARLES R. DREW MENTAL HEALTH CENTER;
EDWARD B. HOSTEN, M.D.

On Appeal From the United States District Court
For the Eastern District of Pennsylvania
(D.C. Civil Action No. 93-cv-00577)

NO. 94-1661

SERENA MARY VISCONTI, DECEASED, BY LINDA
AND RONALD VISCONTI, AS ADMINISTRATORS OF
THE ESTATE OF SERENA MARY VISCONTI,
DECEASED; LINDA VISCONTI; RONALD VISCONTI,
IN THEIR OWN RIGHT,
Appellants

v.

U.S. HEALTH CARE, a/k/a
THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA/NJ

On Appeal From the United States District Court
For the Eastern District of Pennsylvania
(D.C. Civil Action No. 93-cv-06495)

Nos 94-1373 & 94-1661

Present: Stapleton, Roth and Lewis, *Circuit Judges*

JUDGMENT

These causes came on to be heard on the record from the United States District Court for the Eastern District of Pennsylvania and was argued by counsel on December 5, 1994.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgments of the said District Court entered on March 17, 1994 and June 10, 1994, be, and the same are hereby reversed and the causes remanded with instructions to remand the cases to the state courts from which they came. Costs taxed against appellees. All of the above in accordance with the opinion of this Court.

ATTEST:

/s/ P. Douglas Sisk
Clerk

Dated: June 19, 1995

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CECILIA DUKES, Trustee ad litem of the Estate of DARRYL DUKES, Deceased	:	Civil Action No. 93-0577
v.	:	
UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.; GERMANTOWN HOSPITAL AND MEDICAL CENTER; WILLIAM W. BANKS, M.D.; CHARLES R. DREW MENTAL HEALTH CENTER; and EDWARD B. HOSTEN, M.D.	:	

MEMORANDUM AND ORDER

Ditter, J. March 17, 1994

This case was originally brought in state court and involves allegations of negligence on the part of two doctors, two medical centers, and a health maintenance organization ("HMO"). United States Health Care Systems of Pennsylvania, Inc. ("USHC"), the HMO, has moved to dismiss the claims against it on the ground that the state claims are pre-empted by ERISA. For the reasons set forth below, USHC's motion to dismiss Counts I and II will be granted. Plaintiff's motion to remand will be denied in part and granted in part: counts I and II will not be remanded; counts III through X will be remanded.

I. FACTS

Plaintiff's decedent, Darryl Dukes, belonged to an employee group health plan administered by USHC. In August, 1990, Mr. Dukes sought medical attention for various complaints. He visited Dr. William W. Banks M.D., who ordered blood tests, which Germantown Hospital allegedly refused to perform. Decedent visited another doctor, Dr. Edward B. Hosten, M.D., the next day. Dr. Hosten ordered a blood test, which was performed. Decedent's condition apparently worsened and he was admitted to Germantown Hospital, where he died three days later.

Plaintiff, Cecilia Dukes, brought actions in state court against Doctors Banks and Hosten, who had treated Mr. Dukes; Germantown Hospital and Charles R. Drew Mental Health Center, where Drs. Banks and Hosten worked; and USHC. USHC removed Ms. Dukes' suit to this court, contending that her state claims were in fact ERISA claims subject to original jurisdiction here, pursuant to 28 U.S.C. § 1331.[1]

In her third amended complaint,[2] plaintiff makes two claims against USHC. In Count I, a survival action, plaintiff alleges in paragraph 26 that the acts of the defendant doctors and hospitals are imputed to USHC because Mr. Dukes looked to USHC for care and USHC held out the

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[1] Dukes does not dispute that her husband's health plan was an employee benefit plan covered by ERISA, 29 U.S.C. §§ 1001, *et seq.*

[2] All parties refer to this complaint as the "third amended complaint," although in fact it is the second *amended* complaint, albeit the third complaint overall.

other defendants as its agents and employees. Paragraph 27 then alleges certain negligent acts on the part of USHC including failure to exercise reasonable care in selecting, retaining, screening, monitoring, and evaluating the other defendants. In Count II, a wrongful death action, plaintiff incorporates previous allegations and, in paragraph 35, repeats from paragraph 27 the allegations of USHC's particular acts of negligence. In short, plaintiff contends USHC is liable on a theory of vicarious liability and for its own negligence.

As with the other complaints, USHC has moved to dismiss the claims against it, arguing that the claims are "related to" an ERISA plan and are therefore pre-empted by ERISA.

II. DISCUSSION

In crafting ERISA, Congress adopted a broad pre-emption clause. 29 U.S.C. § 1144(a). That section, ERISA's Section 514(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter *relate* to any employee benefit plan. . . . " *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) (emphasis added) (describing "conspicuous" breadth of ERISA's pre-emption clause). Pre-emption applies both to state statutory and common law claims. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987). It follows that if a cause of action brought under state law provisions has some connection with or reference to an employee benefit plan, it "relates" to that plan for ERISA purposes and is governed solely by ERISA. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983). Despite the broad scope of the pre-emption

clause, there are limits. *See, e.g., Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833 (1988) (state garnishment of ERISA welfare benefit plan not pre-empted; dicta states that ERISA plans can be sued for other, run-of-the-mill state law violations such as unpaid rent, failure to pay creditors, and torts which are unrelated to the plan's administration).

Several courts in this district and elsewhere have held that ERISA pre-empts state claims that seek to hold an HMO liable for injuries resulting from the HMO's own negligent administration of cost-containment procedures and funding decisions. *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ERISA pre-empts plaintiff's claim against HMO for denying surgery precertification), *cert. denied*, 114 S. Ct. 964 (1994); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir.) (ERISA pre-empts claim for erroneous medical decision made in context of determining plan benefits), *cert. denied*, 113 S.Ct. 812 (1992); *Elsesser v. Hospital of the Phila. College of Osteopathic Medicine*, 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (ERISA pre-empts direct liability claim for failure to provide funding for medical device); *Kohn v. Delaware Valley HMO*, No. 91-2745, 1991 WL 275609, at *5 (E.D. Pa. Dec. 20, 1991) (same). The basis for ERISA pre-emption in those cases is that a claim for failure to pay a benefit claim or pre-approve a procedure has an obvious connection or reference to a benefit plan and therefore "relates" to it.

Some courts in this district have held, however, that ERISA does not pre-empt state law claims against an HMO sued on a theory of vicarious liability generally or

ostensible agency specifically[3]. *Stratton v. Bryant*, No. 92-3873, 1992 U.S. Dist. LEXIS 18050, at *8 (E.D. Pa. Nov. 18, 1992) (plaintiff's claim alleging vicarious liability of HMO which recommended allegedly negligent doctor not pre-empted); *Elsesser*, 802 F. Supp. at 1290 (plaintiffs' claim alleging vicarious liability of HMO for actions of physician acting ostensibly as HMO's agent not pre-empted); *Kohn*, 1991 WL 275609 at *2 (same); *Independence HMO v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (same). These cases conclude that the negligence claims have nothing to do with a denial of rights under a benefit plan since they do not affect the regulatory scheme devised by Congress in ERISA and thus are not sufficiently "related to" ERISA so as to warrant pre-emption. *E.g.*, *Stratton*, 1992 U.S. Dist. LEXIS 18050 at *8; *Smith*, 733 F. Supp. at 988.

In my view, the same connections to a plan and policy reasons apply whether the claim is for the HMO's own negligence or is being asserted against the HMO on the theory of vicarious liability.

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[3] The theory of ostensible agency is set forth in the Restatement (Second) of Agency § 267. It states:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care of skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

See also Boyd v. Albert Einstein Med. Center, 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) (adopting this section).

To sustain a claim under a theory of ostensible agency, a plaintiff must show that he or she looked to the HMO for medical care and that the HMO held out the supposedly negligent doctor as its employee. *Elsesser*, 802 F. Supp. at 1289-90; *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1233 (Pa. Super. 1988). Paragraph 26 of plaintiff's complaint follows the *Elsesser* language and alleges that her husband looked to USHC (rather than to the individual doctors) for care, and that USHC held out those doctors and hospitals as its agents and employees. This language adequately sets forth a claim based on ostensible agency[4]. I conclude, however, that ERISA'S pre-emption provision encompasses claims that are based

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[4] Having alleged ostensible agency in paragraph 26, Dukes then enumerates in paragraph 27 certain negligent acts committed by USHC, including failing to use reasonable care in selecting, retaining, and evalating health care providers; failing to supervise, monitor, and oversee those providers adequately; and failing to provide competent and qualified physicians. I recognize that the court in *Elsesser* considered these allegations as allegations of vicarious liability. 802 F. Supp. at 1290 (discussing paragraph ii of plaintiff's complaint). I respectfully disagree with that characterization. Rather, I find that the allegations in paragraph 27 – similar to those of paragraph ii of the *Elsesser* complaint – all sound in *direct* negligence and seek to hold USHC directly liable for its own conduct. Vicarious liability, in contrast, is liability for conduct not the fault of the principal. A claim based on the allegations of direct negligence in paragraph 27 would involve examination of how the plan is operated: how USHC chooses its doctors and hospitals, how USHC decides with which doctors and hospitals it will affiliate, whether the doctors are employees of USHC subject to USHC's control or independent contractors. I find that such a claim, involving USHC's administration of the benefit plan, is related to the plan and is pre-empted by ERISA.

on a theory of ostensible agency for two reasons: First, any ostensible agency claim must be made on the basis of what the benefit plan provides and is therefore "related" to it. Second, the treatment received must be measured against the benefit plan and is therefore also "related" to it.

A claim against an HMO based on the ostensible agency of a physician will necessarily involve an examination of what representations were made to its members to determine if the HMO in fact "held out" the physician as its employee. In this case, for example, in order to determine if USHC held out Drs. Hosten and Banks as its employees, the court would have to probe the information USHC provided to Mr. Dukes and how USHC described the relationship between itself and the doctors and hospitals. USHC did not give Mr. Dukes such information in a vacuum. Rather, it would only have done so as part of some description or explanation of the benefit plan. A claim based on such references, descriptions, or explanations is "related to" the benefit plan. Matters relating to a benefit plan are pre-empted by ERISA.

The second reason is equally persuasive: a medical malpractice claim against an HMO, whether couched in direct or vicarious liability terms relates to the benefit plan[5]. One who enrolls in an HMO is assured of medical

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[5] The Third Circuit has held that "ERISA does not generally pre-empt state professional malpractice actions." *Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146, 1153, n. 7 (3d Cir. 1991). *Painters* is distinguishable from the case at bar. *Painters* involved a suit *by* a

services of a given extent and quality. A malpractice claim asserts the services provided did not measure up to the benefit plan's promised quality. The question is one of relating plan performance to plan-promise, and is therefore pre-empted by ERISA. See William A. Chittenden, III, "Malpractice Liability and Managed Health Care: History and Prognosis," 26 Tort & Insur. L. J. 451 (Spring 1991).

Two courts have held recently that ERISA pre-empts state law negligence claims against a benefit plan for the alleged malpractice of the plan's providers because the claims arise from the delivery of health benefits and thus relate to a benefit plan. *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 64 (D. Conn. 1990). *Altieri* involved a claim for dental malpractice in which the plaintiff sued both his dentist and his dental health plan, alleging that the health plan had failed to investigate the dentist's competence before recommending the dentist to patients. 753 F. Supp. at 62. As did Cecilia Dukes, the plaintiff in *Altieri* alleged that the benefit plan was negligent in not evaluating its medical provider and in failing to provide plaintiff with competent professional care. *Id.* The court held that the central feature of the plaintiff's claim was the circumstances of medical treatment under his health services plan, and that the claim was therefore related to a benefit plan and pre-empted by ERISA. *Id.* at 64.

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benefit plan against its professional auditor, not a medical malpractice suit *against* a plan. I do not believe that *Painters* is applicable to a discussion of "professional malpractice actions" in a wholly different context.

The plaintiffs in *Ricci* sought to hold an HMO liable under a theory of vicarious liability for a doctor's failing to advise plaintiff of certain test abnormalities and for careless, reckless treatment. 840 F. Supp. at 316. As did the court in *Altieri*, the court reasoned that the basis of the plaintiffs' claim was the circumstances of Ms. Ricci's medical treatment under her employee medical services plan. *Id.* at 317. Therefore, the court held, the negligence claim "related to" a benefit plan and was pre-empted by ERISA[6]. *Id.*

In summary, I hold that plaintiff's complaint against USHC is pre-empted by ERISA for two reasons. First, plaintiff's allegations of ostensible agency "relate to" Mr. Dukes' benefit plan because the allegations focus on how USHC described to Mr. Dukes its plan benefits and its relationship with its careproviders. Second, I find persuasive the reasoning of *Altieri* and *Ricci* that a malpractice claim against an HMO "relates to" a benefit plan because the claim is based on the circumstances of medical treatment provided pursuant to the plan. Finally, I note a serious reservation about the policy implications of holding an HMO liable for state law claims arising from the negligence of physicians and hospitals. If an HMO such

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[6] Another reason that a malpractice claim premised on the vicarious liability theory of actual, rather than ostensible, agency, relates to a benefit plan is that such a claim would necessarily involve determining if an allegedly negligent doctor was the employee/agent of the HMO. The claim would require examining the HMO-provider contracts and the HMO's management of the benefit plan. It could then be viewed as "related to" the benefit plan and would therefore be pre-empted. *See Ricci*, 840 F. Supp. at 317.

as USHC is obliged to act as a malpractice insurer for health care providers, higher costs will invariably be passed along to health care consumers. I do not comment on whether this spreading of risk and costs is desirable. Rather, I simply hesitate to approve such a potentially widesweeping policy. Congress spent considerable time and effort in debating and passing ERISA, and may soon put similar efforts into so-called health care "reform." If the legislature wishes to examine the scope of ERISA preemption so as to extend malpractice liability to health benefit plans, now may be an appropriate time for it to do so. It does not follow that I should do so.

For all these reasons, I conclude that ERISA preempts the claims in counts I and II which charge USHC with violation of state law. These counts must be dismissed without prejudice. Therefore, USHC's removal of the suit to this court was proper. Plaintiff's motion to remand counts I and II must be refused. The remaining state claims for survival and wrongful death against the other defendants, however, are now solely state claims and must be remanded to the Court of Common Pleas of Philadelphia County. An appropriate order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CECILIA DUKES, Trustee ad litem of the Estate of DARRYL DUKES, Deceased	:	Civil Action No. 93-0577
v.	:	
UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.; GERMANTOWN HOSPITAL AND MEDICAL CENTER; WILLIAM W. BANKS, M.D.; CHARLES R. DREW MENTAL HEALTH CENTER; and EDWARD B. HOSTEN, M.D.	:	

ORDER

AND NOW, this 17th day of March, 1994, it is hereby ordered that:

1. Defendant, United States Health Care Systems of Pennsylvania, Inc.'s, motion to dismiss Counts I and II is GRANTED;

2. Plaintiff's motion to remand Counts I and II is DENIED; and

3. Plaintiff's motion to remand Counts III through X is GRANTED, and those claims are remanded to the Court of Common Pleas of Philadelphia County.

BY THE COURT:

/s/ J. William Ditter, Jr.
J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

SERENA MARY VISCONTI, Deceased by RONALD VISCONTI, as Admin. of the Estate of SERENA MARY VISCONTI, Deceased, and LINDA VISCONTI and RONALD VISCONTI, in their own right,	:	CIVIL ACTION
Plaintiffs,	:	NO. 93-6495
v.	:	
U.S. HEALTH CARE a/k/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA/NJ,	:	
Defendant.	:	

MEMORANDUM

Reed, J. June 8, 1994

Currently before me are the motions of plaintiffs Linda and Ronald Visconti, individually, and as Administrators of the Estate of Serena Mary Visconti, Deceased (collectively "plaintiffs"), to remand this matter pursuant to 28 U.S.C.A. § 1447(c) (West 1994)[1] (Document No. 4)

[1] Although plaintiffs bring their motion to remand as administrators of the Estate of Serena Mary Visconti, the complaint reveals that only Ronald Visconti is the administrator of the Estate. Accordingly, I consider plaintiffs' motion to be brought by Ronald Visconti, individually and as Administrator of the Estate of Serena Mary Visconti, Deceased, and by Linda Visconti in her own right.

and defendant U.S. Health Care a/k/a The Health Maintenance Organization of Pennsylvania/NJ ("USHC") to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief can be granted (Document No. 3). Upon consideration of the motions and the responses thereto, and for the reasons which follow, plaintiffs' motion to remand shall be denied and defendant's motion to dismiss shall be granted.

II. BACKGROUND[2]

This is a case involving state law claims of medical malpractice. Plaintiffs Ronald and Linda Visconti were "participating members" of USHC, an health maintenance organization ("HMO").[3] *See* plaintiffs' complaint at ¶ 8. Plaintiffs do not dispute defendant's statements that their membership in USHC was a benefit provided through Ronald Visconti's employment and that this benefit was part of an employee group health plan that is subject to the Employee Retirement Income Security Act

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[2] I will construe all facts in the light most favorable to the plaintiffs and accept as true all plaintiffs' well-pleaded factual allegations, as I must do when considering a defendant's motion to dismiss. *See Conley v. Gibson*, 355 U.S. 41, 45-46 (1957).

[3] HMO's are extensively regulated both by federal and state statutes. *See* 42 U.S.C.A. § 300e *et seq.* (West 1991) Pa. Stat. Ann. tit. 40, §§ 1553, 1554, 1560 (West 1992); 28 Pa. Code § 9.75(c) (Apr. 1994), 31 Pa. Code § 301.2 (Sept. 1992). Pennsylvania law defines an HMO as "an organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee." Pa. Stat. Ann. tit. 40, §§ 1553.

of 1974, 29 U.S.C.A. §§ 1001, *et seq.* (West 1993 & West supp. 1994) ("ERISA").

Since this is a motion to dismiss, I must accept as true facts alleged in the complaint and all reasonable inferences that can be drawn therefrom. I recognize hereto, however, that the health care delivery system, and HMO's in particular, are closely regulated by federal and state statutes and codes. I do accordingly conclude that to accurately and forthrightfully analyze the claim and motions before me I must refer to and accept as background legal facts the relevant applicable statutory and regulatory pronouncements even though those matters were not pleaded in the complaint. Also, where the defendant, with apparent reliability, makes factual statements in its papers regarding basic organizational facts which are not challenged or refuted by plaintiffs, I will utilize those facts as well. If the foregoing invokes Federal Rule of Civil Procedure 56, which I do not conclude it does, then the motion to dismiss must be considered as a motion for summary judgment.

The circumstances underlying plaintiffs' complaint involve allegedly negligent treatment of plaintiff Linda Visconti by Peter M. Wisniewski, M.D. Plaintiffs claim that Dr. Wisniewski failed to take action during Ms. Visconti's prenatal visits despite his awareness of the details of her condition. According to plaintiffs, Ms. Visconti's condition was permitted to deteriorate to such a degree that by late August, 1991, Ms. Visconti's vital signs, weight, laboratory test results and other findings were, when taken together, outside normal limits. Moreover, a fetal heart beat could not be detected. Upon discovering

this information, Dr. Wisniewski advised Ms. Visconti to go to Pennsylvania Hospital.

When Ms. Visconti was admitted to Pennsylvania Hospital she displayed several complications. The following day Linda Visconti delivered the plaintiffs' decedent, Serena Mary Visconti, a stillborn, fully developed baby girl with no gross congenital abnormalities at 37 weeks gestation weighing at or around 5 pounds and 9 ounces.

Plaintiffs commenced this suit by filing a complaint against USHC in the Court of Common Pleas of Philadelphia County, Pennsylvania. Plaintiffs alleged that, *inter alia*, U.S. Health Care, either individually or acting through its agents, servants and employees, was negligent and careless in the care and treatment of plaintiffs' decedent Serena Mary Visconti and plaintiff Linda Visconti. Shortly thereafter, defendant filed a notice of removal seeking to remove the case to the United States District Court for the Eastern District of Pennsylvania arguing that this Court has jurisdiction pursuant to 28 U.S.C.A. § 1331 (West 1993) and 28 U.S.C.A. § 1441(b) and (c) (West 1994).

USHC has filed a motion to dismiss the complaint in this Court arguing that plaintiffs' claims are preempted by the terms of ERISA. Plaintiffs have responded by filing a motion to remand this matter, asserting that ERISA does not preempt their claims and that, therefore, no federal issue is involved to confer jurisdiction on this Court.

III. DISCUSSION

A. Motion to Remand – Improper Removal

Plaintiffs have moved to remand this matter to state court arguing that their claims are based strictly on state law and, therefore, that this Court is without jurisdiction to hear their claims.[4] Generally, federal courts must comply with the "well-pleaded complaint" rule regarding removal. The rule states that a defendant cannot remove a case to federal court unless the complaint establishes that the case "arises under" federal law. *Nealy v. U.S. Health Care HMO*, 844 F. Supp. 966, 969-70 (S.D.N.Y. 1994); *see Franchise Tax Bd. of California v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 9-10 (1983). Therefore, a federal defense such as preemption, which does not appear on the face of the complaint, ordinarily will be insufficient to permit removal. *Nealy*, 844 F. Supp. at 969-70.

An exception to this general rule applies where Congress so completely preempts a "particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) ("*Metropolitan Life*"). In *Metropolitan Life*, the defendants removed the case to federal court alleging that federal question jurisdiction existed because their claim raised a preemption defense pursuant to ERISA. The Supreme Court concluded that

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[4] Plaintiffs did not bring a claim under ERISA. *See* plaintiffs' complaint; plaintiffs' memorandum of law in support of their answer to motion to dismiss and motion to remand pursuant to 28 U.S.C. § 1447(c) ("plaintiffs' opp.") at 7.

Congress has clearly manifested an intent to make claims that fall within the scope of the civil enforcement provisions of ERISA removable to federal court. Accordingly, because the enforcement provisions of ERISA concern similar issues and policies as those addressed by plaintiffs' cause of action, namely, plaintiffs' right to recover damages based in part on a relationship established by the terms of an employee benefit plan, the defense raised by USHC of preemption pursuant to ERISA constitutes an exception to the well-pleaded complaint rule and forms a basis for removal. *Id.* at 66; *see Nealy*, 844 F. Supp. at 969-70; *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 63 (D. Conn. 1990).

In the instant case, because USHC has raised a preemption defense pursuant to ERISA, and because ERISA claims are " 'necessarily federal in character,' " and plaintiffs' claims fall within the scope of the civil enforcement provisions of ERISA, the removal of this case from state to federal court was properly granted and this Court has jurisdiction over the subject matter involved in this dispute. *Altieri*, 753 F. Supp. at 63 (citations omitted). Consequently, plaintiffs' motion to remand shall be denied.

B. Motion to Dismiss – Preemption of State Law

USHC has filed a motion to dismiss plaintiffs' complaint claiming that plaintiffs' claims are preempted by ERISA. In determining whether or not to grant a motion to dismiss under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief can be granted, I am required to accept " 'as true the facts alleged in the complaint and all reasonable inferences that can be drawn from them.' "

Unger v. Nat'l Residents Matching Program, 928 F.2d 1392, 1394-95 (3d Cir. 1991) (quoting *Markowitz v. Northeast Land Co.*, 906 F.2d 100, 103 (3d Cir. 1990)). Dismissal is allowed under Rule 12(b)(6) for failure to state a claim in those instances where it is clear that no relief could be granted under any set of facts that could be proved. *Id.* at 1395.

When Congress enacted ERISA, it established a comprehensive system for regulating employee welfare benefit programs. 29 U.S.C.A. §§ 1001-1002 (West 1985 & West supp. 1994). The federal statute "provides a detailed system of civil enforcement which limits who may file suit, the grounds for such suits, and the relief to which a litigant is entitled." *Altieri*, 753 F. Supp. at 63. Consistent with this comprehensive scheme, Congress enacted section 514(a) of ERISA, which preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C.A. § 1144(a); *Mackey v. Lanier Collections Agency & Service, Inc.*, 108 S. Ct. 2182, 2185 (1988). This preemption provision has been widely construed and applies to both state statutory and common law claims. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Dukes v. United States Health Care Systems of Pennsylvania, Inc.*, 1994 WL 86338 at *1 (E.D. Pa. March 17, 1994); *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993). The Supreme Court has stated that "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has *a connection with* or *reference to* such a plan." *Pilot Life Ins. Co.*, 481 U.S. at 47 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (emphasis added)). Even indirect state action "bearing on" a health benefit plan may encroach upon an

area of exclusive federal concern. *Metropolitan Life*, 471 U.S. at 739; *Altieri*, 753 F. Supp. at 64 ("any indirect but substantial effect on an employee benefit plan may be sufficient to trigger preemption"). Accordingly, the resolution of defendant's motion depends upon whether plaintiffs' claims of direct and vicarious liability against USHC relate to USHC's employee benefit plan.

Although plaintiffs characterize their claims as sounding *solely* in vicarious liability, it appears that some of plaintiffs' claims are premised upon theories of direct negligence. *See* plaintiffs' opp. at 2, 7. For example, plaintiffs claim that defendant was directly negligent in, *inter alia*, "selecting and employing unqualified personnel in the care and treatment of the plaintiff, Linda Visconti, and plaintiff's decedent," and "not adopting and enforcing adequate rules and policies to insure quality control for its patients." Complaint at ¶ 30(k) and (m). It is well-settled, however, that state law claims against an HMO for the HMO's own negligence are preempted by ERISA. *See Dukes*, 1994 WL 86338 at *2; *Nealy*, 844 F. Supp. at 972-73; *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (plaintiff's claims of direct liability of HMO for failure to provide funding for medical advice is preempted by ERISA); *see also Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). *Cf. Berger v. Edgewater Steel Co.*, 911 F.2d 911, 923 (3d Cir. 1990) (employees' misrepresentation claims related to the employee benefit plan).

The basis for ERISA preemption in those cases is that a claim for failure to pay a benefit claim, pre-approve a procedure, or create adequate rules to guide the conduct

of participating doctors, has an obvious connection to a benefit plan. *Dukes*, 1994 WL 86338 at *2. The ERISA plan is the source of the relationship between the plaintiffs and the defendants and, therefore, inevitably requires reference to the plan. *See Corcoran*, 965 F.2d at 1325, 1331; *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) ("Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself . . . [U]nder the Texas Court's analysis there simply is *no* cause of action if there is no plan."). Moreover, as discussed *infra*, the terms of the plan will help define the services the HMO has undertaken to provide and possibly even limit the HM's responsibilities under the plan. In addition, plaintiffs' claims arise out of the process that USHC undertakes to choose and supervise its physicians, its financial arrangements with those physicians, and its general relationship with USHC. In fact, the relationship between the parties would not exist if not for the employee benefit plan. Accordingly, I conclude that plaintiffs' cause of action based upon USHC's own negligence in the administration or management of the plan is related to the plan and is, therefore, preempted.

While plaintiffs' claims against defendant based on USHC's own negligence are clearly preempted by ERISA, the law is not as well settled regarding ERISA's preemptive effects on claims of vicarious liability against an HMO. *See* complaint at ¶ 30(a-j). In fact, courts in this district are divided regarding this issue. *See Butler v. Wu*,

M.D., 1994 WL 158825 at *4 (D.N.J. April 22, 1994) (agreeing with reasoning in *Altieri*, *Ricci*, and *Dukes* and concluding that ERISA preempts state law claims for alleged negligence); *Dukes*, 1994 WL 86338 at *1 (ERISA preempts state law claims of vicarious liability against HMO); *Ricci*, 840 F. Supp. at 317 (same); *but see Stratton v. Bryant*, 1992 U.S. Dist. LEXIS 18050 at *8 (E.D. Pa. Nov. 18, 1992) (claim alleging vicarious liability against HMO does not affect the regulatory scheme devised by Congress); *Elsesser*, 802 F. Supp. at 1290 (state law claims of vicarious liability against HMO not preempted); *Kohn v. Delaware Valley HMO, Inc.*, 1991 WL 275609 at *2 (E.D. Pa. Dec. 19, 1991) (same), *recons. denied*, 1992 WL 22241 (E.D. Pa. Feb. 5, 1992); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (same).

In *Dukes*, the plaintiffs brought a negligence action against USHC claiming that USHC was liable for the negligent acts of the HMO's participating doctors and hospitals. The court held that claims against an HMO on a theory of vicarious liability were preempted by ERISA. The court proffered two reasons to demonstrate that claims based on vicarious liability "relate to" an employer provided benefit plan. First, the court noted that a successful claim would have to establish that the doctors and hospitals were acting as agents for the HMO and, therefore, any agency claim would relate to a benefit plan because it would necessarily require an analysis of what the benefit plan provided. Second, the court found that a medical malpractice claim against an HMO, whether couched in direct or vicarious liability terms, would relate to a benefit plan because the analysis would require an examination of whether the HMO's agents

measured up to the benefit plan's promised quality. *See Dukes*, 1994 WL 86338 at *2. I find the reasoning in *Dukes* to be persuasive.

Plaintiffs bring their claims against USHC on an agency theory, known in Pennsylvania as an "ostensible agency claim."[5] In Pennsylvania, to establish liability under such a theory, one must demonstrate, first, that there is a likelihood that patients will look to the institution rather than the individual physician for care, and second, that the HMO holds out the physician as its employee.[6] *Boyd*, 547 A.2d at 1232. Holding out occurs " 'when the [HMO] acts or omits to act in some way which leads the patient to a *reasonable* belief he is being treated by the [HMO] or one of its employees.' " *Id.* (quoting *Capan v. Divine Providence Hospital*, 430 A.2d 647, 649 (1980) (emphasis in original)).

As the court noted in *Boyd*, a determination of whether participating physicians are the ostensible

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[5] Pennsylvania's ostensible agency theory creates an exception to the general rule that a principal who engaged another to perform services is not liable for torts committed by the person so engaged if that person is an independent contractor. In accepting this theory of agency, the Superior Court of Pennsylvania noted that several jurisdictions had applied the concept to cases involving hospital liability for the negligence of independent contractor physicians. *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229, 1232 (Pa. Super. 1988); *see* Restatement (Second) of Torts § 429 (1965).

[6] In *Boyd*, the HMO had advertised that its physicians and medical care providers were competent and that they had been evaluated for periods of up to six months prior to being selected to participate in the HMO as medical providers. *Boyd*, 547 A.2d at 1232.

agents of an HMO requires an initial examination of "the arrangement between HMO and participating doctors and their relationship with HMO members." *Id.* In other words, as the court did in *Boyd*, to determine if an agency relationship exists, a court must inspect HMO brochures explaining the features of the program, the HMO directory of participating primary physicians, and the HMO contracts between the HMO, members and participating physicians. *See id.* It is apparent that the analysis of whether an HMO holds its physicians out as its employees relates to, has a connection with, and certainly requires reference to the employee benefit plan. Accordingly, causes of action that require such a determination, like those based on an ostensible agency theory, are preempted by ERISA. *See Ricci*, 840 F. Supp. at 317.[7]

In addition, a vicarious liability claim against an HMO is necessarily *related to* a benefit plan because the requisite quantity and quality of services that are required of the doctors and the plan will be determined at least partly by the terms of the health benefit plan. When an individual enrolls in an HMO, he/she is "assured of medical services of a given extent and quality. A malpractice claim asserts [that] the services provided did not

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[7] *Ricci* involved a claim for negligence against USHC alleging that the HMO failed to advise one of the plaintiffs of abnormalities on a mammogram, and that the treatment administered was performed in a negligent manner. It was undisputed that the plaintiffs sought to maintain their cause of action against USHC on a theory of vicarious liability. Finding that the plaintiffs' claim related to their employee benefit plan, the court concluded that it was preempted by ERISA. *Ricci*, 840 F. Supp. at 316-18.

measure up to the benefit plan's promised quality. The question is one of relating *plan performance* to *plan-promise*, and is therefore pre-empted by ERISA."[8] *Dukes*, 1994 WL 86338 at *2 (emphasis added); *see Rollo v. Maxicare of Louisiana, Inc.*, 695 F. Supp. 245, 248 (E.D. La. 1988) (ERISA preempts the plaintiff's claims since they all "have one central feature: the circumstances of [the plaintiff's] medical treatment under his employer's medical services plan for employees."); *Ricci*, 840 F. Supp. at 317 (same); *Altieri*, 753 F. Supp. at 64 (same).[9]

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[8] Plaintiffs state in their opposition papers that their claims are premised exclusively on the ostensible agency theory. *See* plaintiffs' opp. at 2. Their claims would still be preempted if they were brought under an actual agency theory which plaintiff alleges as well in their complaint. *See* complaint at ¶ 27. This type of claim would require the existence of an employer-employee relationship. In Pennsylvania, an employer is a principal who employs an agent to render services in his affairs and who has the right to control the physical conduct of the employee in the performance of services. *Shuman Estate v. Weber*, 419 A.2d 169, 172 (Pa. Super. 1980). Here, a determination of whether Dr. Wisniewski was an employee or an independent contractor of USHC would require reference to the terms of the contract between the doctor and USHC and an examination of how the HMO managed the benefit plan. Accordingly, if plaintiffs' claims were based on an actual agency theory, they would still be preempted. *See Ricci*, 840 F. Supp. at 317.

[9] *Altieri* involved facts that are very similar to those in the case at bar. In *Altieri*, the plaintiff brought an action against Cigna Dental Health, Inc. ("Cigna") and his dentist, claiming that the dentist failed to provide him with the degree of professional care or skill ordinarily exercised by dentists and that Cigna failed to investigate the dentist's competence as a dentist prior to recommending him to patients subscribing to the employer's dental health plan it administered. The court held that the plaintiff's claims of negligence related to the employee

My conclusion that Congress intended to preempt vicarious liability claims against HMO's is buttressed by the anomalous situation that would result where the liability of an HMO would be inversely proportional to the extent of the HMO's involvement in the provision of services. *See Ricci*, 840 F. Supp. at 318. HMO's that are directly negligent would be shielded from state law, while those that did not act improperly would be subject to liability because of the negligent conduct of their participating doctors. Because I do not believe Congress intended such a result, I conclude for this additional reason that vicarious liability claims against HMO's are preempted by ERISA.[10]

In reaching this decision, I am aware that the result will be different than that reached by some other courts in this district. *See Stratton*, 1992 U.S. Dist. LEXIS 18050 at *8; *Elsesser*, 802 F. Supp. at 1290; *Kohn*, 1991 WL 275609 at *2. These cases rely, at least in part, on the decision in *Independence HMO, Inc.*, 733 F. Supp. at 988. In that case, the court held that a patient's medical malpractice action against an HMO brought under an "ostensible agency" theory was not preempted by ERISA. The court reasoned

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benefit plan and, thus, was preempted by ERISA. *Altieri*, 753 F. Supp. at 62-64.

[10] Moreover, as the court noted in *Ricci*, Congress crafted the breadth of ERISA's preemption provision in an effort to balance many competing interests. The choices reflected in the inclusion of certain remedies and the exclusion of others would be completely undermined if ERISA-plan participants and beneficiaries could obtain remedies under state law that Congress rejected in ERISA. *Ricci*, 840 F. Supp. at 318 (quoting in part *Pilot Life Ins. Co.*, 481 U.S. at 54).

that state tort actions that impact upon ERISA in an indirect manner that are too tenuous or too remote are not preempted by ERISA. The court found that the suit brought by the patient had "nothing to do with any denial of her rights under the plan . . . '[T]he Congressional purpose underlying the breadth of ERISA's preemption provision – to secure uniform federal laws regulating employee benefit plans – is not advanced by preemption of state common law claims which are not premised on a violation of duties imposed by ERISA.' " *Independence HMO, Inc.*, 733 F. Supp. at 988.

I do not agree with the reasoning expressed in *Independence HMO, Inc.* First, for the reasons stated earlier, I find that state law claims against an HMO brought on a theory of vicarious liability *do* affect the regulatory scheme devised by Congress. Second, no Supreme Court case interpreting the broad preemption clause provided in ERISA has limited that provision only to common law claims premised on the violation of duties imposed by ERISA. To the contrary, the Supreme Court has established a much lower standard for ERISA preemption, requiring only that state laws have a connection with or reference to a benefit plan. As a result, ERISA preemption does not only apply to a state law claim based on the express provisions of a benefits plan, it applies to state laws that merely affect the plan in a substantial way.[11]

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[11] Both plaintiff here and the court in *Elsesser* rely on the statement by the Court of Appeals for the Third Circuit in *Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse*, that, "[w]e acknowledge appellants' argument that ERISA's broad preemption provision, 29 U.S.C. § 1144(a), preempts state professional malpractice claims as they relate to

Pilot Life Ins. Co., 481 U.S. at 46-47; *Metropolitan Life*, 471 U.S. at 739.

Here, at a minimum, a state law that holds an HMO responsible for the acts of its participating doctors would affect the health benefit plan by requiring the health organization to carry additional insurance coverage to protect against claims brought against its doctors. This, ultimately, would result in an increase of costs to the end user. *See Ricci*, 840 F. Supp. at 318. Moreover, HMO's and doctors would inevitably be forced to redefine the relationship between all parties, either to enable the HMO to avoid liability or to compel it to come under the umbrella of responsibility. In any case, it is not the role of the courts to force such action in the face of such an extensive

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ERISA, but we are not persuaded by it." 879 F.2d 1146, 1153 n.7 (3d Cir. 1989). *Price Waterhouse* is wholly inapplicable to the instant case.

Price Waterhouse involved a suit by a welfare fund against an accounting firm that performed several yearly audits for the fund. The plaintiff-fund argued, *inter alia*, that ERISA created an implied cause of action in favor of the fund against its auditors. The court's statement above regarding the breadth of ERISA's preemption was made in the context of refuting the fund's argument that an implied right of action under ERISA was necessary because state professional malpractice claims were preempted by ERISA. This case did not involve whether ERISA preempted state law malpractice claims *against* a benefit plan based generally on the terms of the plan, rather, it concerned a run-of-the-mill state law claim by a fund (client) against its accountants. *See Dukes*, 1994 WL 86338 at *4 n.5 ("I do not believe that *Painters* is applicable to a discussion of 'professional malpractice actions' in a wholly different context.").

congressional scheme of rules and regulations as provided by ERISA. If Congress desires to alter the balance it has reached, it has the ability and resources to do so.

It is important to note that HMO's often perform functions akin to those of insurers. *See Butler,* 1994 WL 158825 at *5. In fact, HMO's in Pennsylvania are subject to certain Pennsylvania insurance laws. *See* Pa. Stat. Ann. tit. 40, § 1560(b). In this case, defendant argues that it has not acted as a health care provider, rather it finances the health care delivered to the members for a fixed, prepaid fee. *See* defendant's motion at 4; *see also* Pa. Stat. Ann. tit. 40, § 1553 (defining "direct provider" as "an individual who is a direct provider of health care services under a benefit plan of a health maintenance organization or an individual whose primary current activity is the administration of health facilities in which such care is provided); 31 Pa. Code § 301.2 (defining "provider" as "[a] physician, hospital, or other person licensed and practicing within the scope of the license or otherwise authorized in this Commonwealth to furnish health care services."); *Elsesser,* 802 F. Supp. at 1290 ("Although an HMO is not usually liable for the negligence of the independent contractor physicians and health care providers that services the HMO members, an HMO may nevertheless be held liable if the health care provider is the 'ostensible agent' of the HMO."). It is not alleged and there is no suggestion in this record that USHC operates any facility, clinic, hospital or that it is licensed to do so. Accordingly, I conclude from this record that USHC is not a "direct provider" or a "provider" as defined under Pennsylvania law.

Plaintiffs do not dispute that their claims are not based upon the medical treatment actually provided by USHC, stating in their opposition papers that their claims are "premised on the ostensible agency theory by which USHC may be held vicariously liable for the negligence of the treating obstetrician." Plaintiffs' opp. at 2; *see* plaintiffs' opp. at 7 ("Plaintiffs are seeking to hold USHC vicariously liable for the negligence of the treating obstetrician under the ostensible agency theory."). Moreover, plaintiffs' reliance on cases that involve HMO's that do not perform direct medical services and plaintiffs' suggestion that those cases are similar to the instant case also confirm that plaintiffs' claims sound in vicarious liability and not in liability as a direct provider. *See* plaintiffs' opp. at 6. *See also Dukes*, 1994 WL 86338 at *1, *3 (not treating United States Health Care Systems of Pennsylvania, Inc. as a direct provider of health care services); *Elsesser*, 802 F. Supp. at 1290 (describing United States Health Care Systems of Pennsylvania, Inc. as an HMO that hires independent contractors to serve as direct providers of health services); *Kohn v. Delaware Valley HMO, Inc.*, 1991 WL 275609 at *2 (E.D. Pa. Dec. 20, 1991) (U.S. Healthcare, Inc. was not the direct health care provider); *McCarty v. U.S. Healthcare*, 1990 WL 107605 (E.D. Pa. July 26, 1990) (U.S. Health Care, The Health Maintenance Organization of New Jersey, Inc. treated in a manner similar to insurance company rather than direct provider).

Finally, in all five counts of the complaint, plaintiffs allege claims based on the negligence of USHC. *See* plaintiffs' opp. at 7 ("plaintiffs' complaint alleges *only* negligence claims against USHC." (emphasis in original)); *see also Dukes*, 1994 WL 86338 at *1 (plaintiff's survival and

wrongful death actions are grounded on theories of direct and vicarious liability and, therefore, are preempted); *Nealy*, 844 F. Supp. at 973. Because I have concluded that claims of negligence against an HMO for its own negligence and for the negligence of its participating doctors are preempted by ERISA, and because plaintiffs have not alleged any federal claims under ERISA, USHC's motion to dismiss plaintiffs' complaint shall be granted.

IV. CONCLUSION

Having concluded that this Court has jurisdiction to consider whether plaintiffs' state law claims of medical malpractice are preempted, and having concluded that plaintiffs' state law claims are preempted by ERISA, and having found that plaintiffs have brought no federal claims under ERISA, and for the foregoing reasons, the motion of plaintiffs Linda and Ronald Visconti, individually, and as Administrators of the Estate of Serena Mary Visconti, Deceased, to remand shall be denied and the motion of defendant U.S. Health Care a/k/a The Health Maintenance Organization of Pennsylvania/NJ to dismiss the complaint shall be granted.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

SERENA MARY VISCONTI, Deceased by RONALD VISCONTI, as Admin. of the Estate of SERENA MARY VISCONTI, Deceased, and LINDA VISCONTI and RONALD VISCONTI, in their own right,	:	CIVIL ACTION
Plaintiffs,	:	(Filed Jun. 9, 1994)
v.	:	
U.S. HEALTH CARE a/k/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA/NJ,	:	
Defendant.	:	NO. 93-6495

ORDER

AND NOW, this 8th day of June 1994, upon consideration of the motions of plaintiffs Linda and Ronald Visconti, individually, and as Administrators of the Estate of Serena Mary Visconti, Deceased, to remand pursuant to 28 U.S.C. § 1447(c)[1] (Document No. 4) and defendant

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[1] Although plaintiffs bring their motion to remand as administrators of the Estate of Serena Mary Visconti, the complaint reveals that only Ronald Visconti is the administrator of the Estate. Accordingly, I consider plaintiffs' motion to be brought by Ronald Visconti, individually and as Administrator of the Estate of Serena Mary Visconti, Deceased, and by Linda Visconti in her own right.

U.S. Health Care a/k/a The Health Maintenance Organization of Pennsylvania/NJ to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b)(6) (Document No. 3), and the responses thereto, and for the reasons stated in the attached memorandum, it is hereby **ORDERED** that the motion of plaintiffs to remand is **DENIED,** and the motion of defendant to dismiss the complaint is **GRANTED.** Accordingly, the complaint is **DISMISSED** with prejudice.

This is a final disposition of all claims.

/s/ Lowell A. Reed, Jr.
LOWELL A. REED, JR., J.

ENTERED: 6/10/94
CLERK OF COURT

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

SERENA MARY VISCONTI, Deceased by RONALD VISCONTI, as Admin. of the Estate of SERENA MARY VISCONTI, Deceased, and LINDA VISCONTI and RONALD VISCONTI, in their own right,	:	CIVIL ACTION
Plaintiffs,	:	(Filed Jul. 7, 1994)
v.	:	
U.S. HEALTH CARE a/k/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA/NJ,	:	
Defendant.	:	NO. 93-6495

ORDER

AND NOW, this 5th day of July, 1994, pursuant to Third Circuit Local Appellate Rule 3.1, having found that it would be helpful to clarify my June 8, 1994 Memorandum filed in this matter (Document No. 9), and having no intention to change or modify the result and having, therefore, found that the following changes are for clarification purposes *only*, it is hereby **ORDERED** that the following alterations are made to that Memorandum:

(1) On page two, first full paragraph, first sentence now shall read, "This is a case involving state law claims of medical malpractice."

(2) On page four, second full paragraph, at the end of first sentence insert new footnote number four.

(3) On page sixteen, first full paragraph, last sentence now shall read, "Because I have concluded that claims of negligence against an HMO for its own negligence and for the negligence of its participating doctors are preempted by ERISA, and because plaintiffs have not alleged any federal claims under ERISA, USHC's motion to dismiss plaintiffs' complaint shall be granted."

(4) On page seventeen, first full paragraph now shall read, "Having concluded that this Court has jurisdiction to consider whether plaintiffs' state law claims of medical malpractice are preempted, and having concluded that plaintiffs' state law claims are preempted by ERISA, and having found that plaintiffs have brought no federal claims under ERISA, and for the foregoing reasons, the motion of plaintiffs Linda and Ronald Visconti, individually, and as Administrators of the Estate of Serena Mary Visconti, Deceased, to remand shall be denied and the motion of defendant U.S. Health Care a/k/a The Health Maintenance Organization of Pennsylvania/NJ to dismiss the complaint shall be granted."

Having further found that it would be clearer to view the Memorandum in its entirety, a new clarified version is attached hereto. The Order dated June 8, 1994, attached to the original Memorandum filed on that same date, is unaffected by this Order.

/s/ Lowell A Reed Jr
LOWELL A. REED, JR., J.

ENTERED: 7/7/94
CLERK OF COURT